TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CHARLES KENNEDY, MD

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-16-3573-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
AUGUST 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting a reconsideration as the HCFA 1500 was sent to your office the first time in the 95 days time period. When this appointment was authorized by Lea Lilley with Coventry Claims the HCFA was faxed to Lea Lilley (see attachment). I have spoke to Lea Lilley and that she did in fact receive the HCFA 1500 on 06/23/2015 and was forward to proper carrier for payment. Since I had not received any kind of EOB or correspondence regarding the claimant I emailed Lea w/Coventry and asked me to send her all documentation to her again on 10/15/2015. I was denied payment due to missing documentation on 11/09/2015. I then sent via mail all supporting documents to the Adjuster mentioned on EOB (Pritchard) since there was no mention of Adjuster name on any other form. I was then denied again on 12/15/2015 due to code (*45) Charge exceed fee exceeds fee allowable. I appealed on 12/22/2015 since I feel like billing amount does not exceed fee allowable. I charges less than I was supposed to (Allowable in Houston area for 16 units is $844.53). After I sent appeal in December, I had yet to receive any king of EOB so I emailed Lea w/Coventry for status and also sent a letter to Gallagher Bassett on 7/12/2016 for status. I then received another EOB dated 07/21/2016 with code (*29) the time limit for filing has expired. I feel like this has been an oversight of billing department and I am sending supporting documents for your review."

Amount in Dispute: $799.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

Respondent's Supplemental Position Summary: "the bill in question was escalated and the review has been finalized. Our bill audit company has determined no further payment is due."

Responses Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2015	Functional Capacity Evaluation CPT Code 97750-FC (X16 Units)	$799.07	Untimely

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 29-The time limit for filing has expired.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of service in dispute is June 18, 2015. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 1, 2016. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Elizabeth Pickle, RHIA Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.